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App. A, III. E.4.

4. Limitations and Exclusions

a. Dental services, including extra on of teeth, except as provided for i ection III.E.3.a.(2), are not covered uer this subsection.

b. Examinations and tests in connection with research studies, paternity determinations, weight control, autopsies, insurance, pre-employment or premarital examinations are not covered.

c. Services of stand-by physicians are not covered.

d. Services relating to refractive eye surgery (e.g., radial keratotomy, corneal sculpting or similar surgical procedures to correct vision) are not covered.

e. Invasive electromagnetic bone growth stimulation is not covered.

f. Growth factor treatment for wound care (e.g., Procuren) is not covered.

g. Positron emission tomography (PET) scanning is not covered.

h. Thermography services are not covered.

i. Coverage for surgical and medical services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

F. Ambulance Service Coverage

1. Conditions of Benefit Payments
Ambulance services are covered if the following conditions and requirements are met:

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App. A, III. F.1.a

a. Ambulance services must be medically necessary. Ambulance services are not medically necessary if any other means of transportation could be used without endangering the patient's health.

b. The ambulance operation providing the service must be licensed and meet Program standards.

c. A physician must prescribe the services which necessitate the use of ambulance transportation.

2. Coverages

The reasonable and customary charges for the following services are covered when furnished and billed by an eligible provider (as determined by the carrier):

a. Charges for basic life support services -- a standard charge per trip inclusive of use of vehicle and equipment, supplies and personnel required to perform services classified as basic life support services. Basic life support consists of services which provide for the initial stabilization and transport of a patient.

b. Charges for advanced life support services -- a standard charge per trip inclusive of use of vehicle and equipment, supplies and personnel required to perform services classified as advanced life support services. Advanced life support is acute emergency treatment procedures with physician involvement.

c. Mileage charges -- a charge per mile for distances traveled while the enrollee occupies the ambulance vehicle.

SALARIED HEALTH CARE PROGRAM

App. A, III. F.2.d.

d. Waiting time -- a charge for waiti ; time involved in round-trip transport ' an enrollee from a hospital to anoth treatment site and return to the .ne hospital.

When services are received from an ar . .ance operation approved by the carrier, t.. carrier will reimburse the provider for the reasonable and customary charges as determined by the carrier. An approved provider must agree to accept, as payment in full, the carrier's determination of the amount payable for covered ambulance services.

When services are received from an otherwise eligible, but non-approved provider, the carrier will pay the enrollee the reasonable and customary charge as determined by the carrier.

3. Limitations and Exclusions

a. The following services are not covered as separate charges; such charges are included in the benefit payment for the standard charge per trip:

(1) Use of specific equipment or devices;

(2) Gases, fluids, medications, dressings, or other supplies;

(3) First aid, splinting, or any emergency medical services or personal service procedures; and

(4) Vehicle operators, attendants, or other personnel.

The charges for these services, while not covered as separate charges, are covered as a component of the charge for the basic or advanced life support services.

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App. A, III. F.3.b.

b. Coverage is limited to the reasonable and customary charges for transporting the patient to the nearest medical facility qualified to treat the enrollee.

c. Services of air and boat ambulance are subject to individual review.

(1) If the patient is transported to a facility other than the nearest medical facility qualified to treat the enrollee, benefits are allowed in an amount equal to that for transportation to the nearest facility.

(2) If transport by air or boat is not medically necessary, benefits are allowed in an amount equal to that for ground transportation for the same transfer.

d. Coverage does not include the following:

(1) Transportation in a vehicle not qualified as an ambulance;

(2) Transportation for enrollee, family or physician convenience;

(3) Services rendered by fire departments, rescue squads or others whose fee is in the form of a voluntary donation;

(4) Transfers not medically necessary;

(5) Fees, billed by physicians or other independent health care providers, for professional services rendered to enrollees transported by ambulance;

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App. A, III. F.3.d.(6)

(6) Fees for services when the enrollee is not actually transported while under care; and

(7) Services which are payable through an existing arrangement for transfer of patients, where no additional charge is usually made, whether or not such services were immediately available.

e. Coverage for ambulance services is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

G. Prescription Drug Coverage

1. Definitions

For the purposes of this subsection:

a. "copayment" means an amount to be paid by the enrollee for each separate prescription order or refill of a covered drug.

b. "covered drug or supplies" means insulin or any prescription legend drug (except as excluded under subsection G.5. below) that is dispensed according to a prescription order, provided that:

(1) the drug is medically necessary for the treatment of an illness or injury;

(2) the cost of the drug is not included or includable in the cost of other services or supplies provided to the enrollee;

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App. A, III. G.1.b.(3)

(3) the drug is customarily dispensed according to a prescription order; and

(4) the drug is not entirely consumed at the time and place of the prescription order.

"Supplies" refers to syringes and needles dispensed with injectable insulin or covered self-administered antineoplastic or chemotherapeutic drugs or agents under the provisions of this subsection.

c. "nonparticipating provider" means a provider who has not entered into a contract with the carrier.

d. "participating provider" means a provider who has entered into a contract with a carrier to provide a covered drug to an enrollee, in accordance with the provisions of this Program and this subsection. Such contract shall provide for payment to the provider based on prescription charges. Until implementation of a national prescription drug network applicable to non-HMO enrollees, in the case of a preferred provider organization, participating providers are the organization's panel pharmacies.

e. "pharmacist" means a person licensed to dispense prescription legend drugs under the laws of the state where such person practices.

f. "pharmacy" means a licensed establishment where prescription legend drugs are dispensed by a pharmacist.

g. "prescription charge" means the acquisition cost to the provider for the covered drug (including disposable syringes and needles) plus a dispensing fee. The "acquisition cost" is the actual

App. A, III. G.1.g.

cost (price) which is paid for a drug by the provider (pharmacy, physician, dentist) or by a company, organization or its affiliates with which the provider may be associated, or such amount as may be negotiated by the carrier with participating providers. This cost will include trade discounts but will not include cash discounts. The "dispensing fee" is an amount or amounts, including applicable sales tax, predetermined by the carrier to compensate participating providers for dispensing covered drugs. Exceptions are:

(1) injectable insulin - for which the prescription charge means the lower of the reasonable and customary charge as determined by the carrier or the acquisition cost plus the dispensing fee; and

(2) covered drugs obtained from a nonparticipating provider or from a provider in an area where the carrier does not provide the coverage - for which the prescription charge means the reasonable and customary charge as determined by the carrier.

h. "prescription legend drug" means any medicinal substance, the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend "Caution: Federal law prohibits dispensing without a prescription" and includes compounded medications containing at least one prescription legend drug.

i. "prescription order" means a written or oral request to a provider by a physician for a single prescription legend drug.

j. "provider" means a pharmacy or any other organization or person licensed to dispense prescription legend drugs.

SALARIED HEALTH CARE PROGRAM

App. A, III. G.2.

2. Reimbursement

a. The copayment amount for each separate prescription order or refill of a covered drug shall be 20% of the prescription charge, as defined in 1.g. of this subsection III.G., except that the copayment shall be:

(1) The prescription charge, if that amount is less than or equal to $8;

(2) Not less than $8, if the prescription charge exceeds that amount;

(3) Not more than $25; and

(4) $8 for prescriptions dispensed through the Mail Order Prescription Drug program.

b. Except for the copayment, covered drugs or supplies obtained from a participating provider are covered subject to the Program provisions.

c. Upon proof of payment acceptable to the carrier, an enrollee is entitled to reimbursement from the carrier of 75% of the reasonable and customary charge, as determined by the carrier after deduction of the copayment, of covered drugs obtained on a non-emergency basis from a nonparticipating provider located within the area in which the carrier provides coverage.

d. Upon proof of payment acceptable to the carrier, an enrollee is entitled to reimbursement from the carrier of 100% of the reasonable and customary charge, as determined by the carrier after deduction of the copayment, of covered drugs obtained from a provider located outside the area in which the carrier provides coverage or from an in-area nonparticipating provider in the case of an emergency as determined by the carrier;.

SALARIED HEALTH CARE PROGRAM

App. A, III. G.3.

3. Coverage

a. Coverage includes up to a 34-d / s: ly of a covered drug unless otherwi: sp. .fied in c. below.

b. Coverage includes an appropr.ate pply of disposable syringes and needles n prescribed for self-injection w .. a supply of insulin or an antineop.astic or chemotherapeutic agent.

c. Coverage includes up to a 90-day supply of covered drugs obtained through the Mail Order Prescription Drug program with a corresponding prescription or refill order.

4. Maximum Allowable Cost Programs

Maximum Allowable Cost (mandatory generic substitution) prescription drug programs or alternative generic substitution programs are applicable where in effect.

5. Limitations and Exclusions

a. Transdermal nicotine patches, nicotine gum or any other medication or prescription legend drug used for or in connection with the control or cessation of smoking are covered only if ordered through the Mail Order Prescription Drug program.

(1) Transdermal patches are limited to one continuous 12-week supply, lifetime maximum.

(2) Nicotine gum is limited to one continuous six-month supply, lifetime maximum.

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App. A, III. G.5.b.

b. Coverage under this subsection does not include:

(1) any research or experimental agent including Federal Food and Drug Administration approved drugs which may be prescribed for research or experimental treatments;

(2) any charge for a contraceptive medication, regardless of intended use, or any charge for a medication being used for a cosmetic purpose, even if the medication is a prescription legend drug;

(3) any prescription legend drug prescribed for the purpose of attempting to induce pregnancy;

(4) any charge for a prescription legend drug prescribed for weight control or appetite suppression;

(5) any charge for devices or appliances (e.g., orthotics, and other non-medical items);

(6) any vaccine administered for the prevention of infectious diseases;

(7) any charge for administration of covered drugs;

(8) any charge for a covered drug in excess of the quantity specified by the physician, or any refill dispensed after one year from the physician's order;

(9) any charge for more than a 34-day supply of a covered drug provided by a retail pharmacy, or any charge for more than a 90-day supply of a covered drug supplied through the Mail Order Prescription Drug program;

SALARIED HEALTH CARE PROGRAM

App. A, III. G.5.b.(10)

(10) any charge for medications [illegible]shed on an inpatient or outpatie[illegible]asis covered under any other sub[illegible]ion of this Appendix or under any s[illegible]section of Appendix B; and

(11) any charge for drugs received prior to the effective date of this coverage.

c. Coverage under this subsection is subject to the Terms and Conditions of Section II, and the Limitations and Exclusions of Section IV.

H. Hearing Aid Coverage

1. Definitions

For the purposes of this subsection:

a. "physician" means a participating otologist or otolaryngologist who is board certified or eligible for certification in such specialty in compliance with standards established by the respective professional sanctioning body, who is a licensed doctor of medicine or osteopathy legally qualified to practice medicine and who, within the scope of such license, performs a medical examination of the ear and determines whetner the patient has a loss of hearing acuity and whether the loss can be compensated for by a hearing aid;

b. "audiologist" means any participating person who (1) possesses a master's or doctorate degree in audiology or speech pathology from an accredited university, (2) possesses a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association and (3) is qualified in the state in which the service is provided to conduct an audiometric examination and

SALARIED HEALTH CARE PROGRAM

App. A, III. H.1.b.

hearing aid evaluation test for the purposes of measuring hearing acuity and determining and prescribing the type of hearing aid that would best improve the enrollee's loss of hearing acuity. A physician performing the foregoing services shall be deemed an audiologist for purposes of this subsection;

c. "dealer" means any participating person or organization that sells hearing aids prescribed by a physician or audiologist to improve hearing acuity in compliance with the laws or regulations governing such sales, if any, of the state in which the hearing aids are sold;

d. "provider" means a physician, audiologist or dealer;

e. "participating" means having a written agreement with the carrier pursuant to which services or supplies are provided under this subsection;

f. "hearing aid" means an electronic device worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing, and includes an ear mold, if necessary;

g. "ear mold" means a device of soft rubber, plastic or a non-allergenic material which may be vented or nonvented that individually is fitted to the external auditory canal and pinna of the enrollee;

h. "audiometric examination" means a procedure for measuring hearing acuity that includes tests relating to air conduction, bone conduction, speech reception threshold and speech discrimination;

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App. A, III. H.1.i.

i. "hearing aid evaluation test" means a series of subjective and objective tests by which a physician or audiologist determines which make and model of hearing aid will best compensate for the enrollee's loss of hearing acuity and which make and model will therefore be prescribed, and shall include one visit by the enrollee subsequent to obtaining the hearing aid for an evaluation of its performance and a determination of its conformity to the prescription;

j. "dispensing fee" means a fee predetermined by the carrier to be paid to a dealer for dispensing hearing aids, including the cost of providing ear molds, under this subsection;

k. "acquisition cost" means the actual cost to the dealer of the hearing aid.

2. Conditions of Benefit Payments

An enrollee is eligible for benefits for covere hearing aid expenses subject to the provisions below.

a. Charges incurred for audiometric examinations are covered to the extent that these charges are reasonable and customary when performed by a physician or audiologist, but only following or in conjunction with the most recent medical examination of the ear by a physician.

b. Hearing aid evaluation tests are covered only when indicated by the most recent covered audiometric examination up to $96 per test or, if higher, the adjusted maximum

App. A, III. H.2.b.

determined under subsection e. below. Hearing aid evaluations performed by a physician or audiologist include the trial and testing of various makes and models of hearing aids to determine which one will best compensate for the loss of hearing acuity.

c. Standard hearing aids are covered if:

(1) they are of the following functional design: in-the-ear, behind-the-ear (including air conduction and bone conduction types) or on-the-body;

(2) they are prescribed based upon the most recent audiometric examination and most recent hearing aid evaluation; and

(3) the hearing aid provided by the dealer is the make and model prescribed by the physician or audiologist and is certified as such by the physician or audiologist. Binaural hearing aids will be provided only for children under 19 years of age with a hearing loss in both ears.

d. In order for the charges for services and supplies described in b. and c. immediately above to be covered under this subsection, upon each occasion that an enrollee receives such services and supplies the enrollee must first obtain a medical examination of the ear by a physician, and such examination or such examination in conjunction with the audiometric examination must result in a determination that a hearing aid would compensate for the loss of hearing acuity and, in the case of binaural hearing aids for children, would correct or prevent speech impairment.

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App. A, III. H.2.e.

e. The maximum covered expense for [illegible]aring aid evaluation test shall be ad[illegible] on October 1 of each year, by the [illegible]tage increase as of the July levels [illegible] United States Consumer Price [illegible] for the immediately preceding 12 mon[illegible] The result will be rounded to th[illegible] nearest dollar.

3. Coverages

The enrollee may obtain audiometric examinations, hearing aid evaluation tests and hearing aids that the provider shall have agreed to furnish enrollees in accordance with the following reimbursement arrangements:

a. for an audiometric examination, the reasonable and customary charge;

b. for hearing aid evaluation tests, the reasonable and customary charge, but not to exceed the amount as provided in subsections H.2.b. and e.; and

c. for covered hearing aids, the acquisition cost and dispensing fee.

If the enrollee requests services or devices from the provider which are not covered under these provisions (e.g.- binaural hearing aids for enrollees over 19), the enrollee shall pay the full additional charge.

4. Frequency Limitations

If an enrollee has received an audiometric examination, a hearing aid evaluation test or a hearing aid for which benefits were payable under this subsection, benefits will be payable for each subsequent audiometric examination, hearing aid evaluation test or hearing aid only if received more than 36 months after receipt of the most recent previous audiometric examination, hearing aid evaluation test and hearing aid, respectively, for which benefits were payable under this subsection.

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App. A, III. H.5.

5. Exclusions

Covered hearing aid expenses do not include and no benefits are payable for:

a. audiometric examinations by an audiologist that are not ordered by a physician;

b. medical or surgical treatment;

c. drugs or other medication;

d. audiometric examinations, hearing aid evaluation tests and hearing aids provided under any applicable Worker's Compensation law;

e. audiometric examinations and hearing aid evaluation tests performed, and hearing aids ordered:

(1) before the enrollee became eligible for coverage; or

(2) after termination of the enrollee's coverage;

f. hearing aids ordered while covered but delivered more than 60 days after termination of coverage;

g. audiometric examinations, hearing aid evaluation tests and hearing aids for which no charge is made to the enrollee or for which no charge would be made in the absence of hearing aid coverage;

h. audiometric examinations, hearing aid evaluation tests and hearing aids which are not necessary, according to professionally accepted standards of practice, or which are not recommended or approved by the physician;

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App. A, III. H.5.i.

i. audiometric examinations, hearing a evaluation tests and hearing aids t do not meet professionally accept s dards of practice, including any suc se ices or supplies that are experimenta ir ature;

j. audiometric examinations, he ir aid evaluation tests and hearin aic received as a result of ear disease, defect or injury due to an act of war, declared or undeclared;

k. audiometric examinations, hearing aid evaluation tests and hearing aids provided by any governmental agency that are obtained by the enrollee without cost by compliance with laws or regulations enacted by any Federal, state, municipal or other governmental body;

l. audiometric examinations, hearing aid evaluation tests and hearing aids to the extent benefits therefor are payable under any health care program supported in whole or in part by funds of the Federal government or any state or political subdivision thereof;

m. replacement of hearing aids that are lost or broken unless at the time of such replacement the enrollee is otherwise eligible under the frequency limitations set forth herein;

n. replacement parts for and repairs of hearing aids;

o. charges incurred by enrollees of a health maintenance organization option;

p. eyeglass-type hearing aids, to the extent the charge for such hearing aid exceeds the covered hearing aid expense for one hearing aid under this subsection;

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App. A, III. H.5.q.

q. binaural hearing aids except as provided in this subsection for children under 19 years of age; and

r. digital-controlled/programmable hearing devices, to the extent the charge for such hearing device exceeds the covered expense for a standard, conventional hearing aid.

I. Durable Medical Equipment and Prosthetic and Orthotic Appliance Coverage

1. Conditions of Benefit Payments

An enrollee is eligible for benefits for the rental or purchase of durable medical equipment and the purchase of prosthetic and orthotic appliances only when the following conditions have been met:

a. the items rented or purchased are basic equipment or appliances or are medically necessary special features which are prescribed by the attending physician and approved by the carrier;

b. the equipment or appliances are prescribed by a physician and the prescription includes a description of the equipment and the reason for use or the diagnosis;

c. for purchased durable medical equipment or prosthetic or orthotic appliances, the order must be placed on or after the effective date and prior to the termination date of the enrollee's coverage in this Program; and

d. for rented durable medical equipment, the rental period is on or after the effective date and prior to the termination date of the enrollee's coverage in this Program.

SALARIED HEALTH CARE PROGRAM

App. A, III. I.2.

2. Payment of Services

a. The carrier will make payment for the reasonable and customary charge for rental or purchase of durable medical equipment when obtained from a provider other than a hospital or skilled nursing facility. Benefit payments for rental of durable medical equipment shall not exceed the purchase price of such equipment.

b. The carrier will make payment for the reasonable and customary charge for external prostheses and orthotic appliances.

3. Coverages

a. Durable Medical Equipment

(1) Unless otherwise indicated below, the equipment must be an item of durable medical equipment which meets Program standards including being approved for reimbursement under Medicare Part B as of October 1, 1993 and be appropriate for use in the home.

(2) Durable medical equipment is covered when used in a hospital or skilled nursing facility, or when used outside the hospital or skilled nursing facility and rented or purchased from such hospital or facility upon discharge.

(3) When the equipment is rented and the rental period extends beyond the expiration of the original prescription, the physician must recertify by another prescription that the equipment continues to be reasonable and medically necessary for the treatment of the illness or injury or to improve the functioning of a malformed body member. If the

App. A, III. I.3.a.(3)

recertification is not submitted, coverage will cease on the date indicated on the original prescription for duration of need, or 30 days after the date of death, whichever is earlier. Coverage will not be provided for rental charges in excess of the purchase price of the equipment.

(4) When the equipment is purchased, coverage is provided for repairs necessary to restore the equipment to a serviceable condition. Routine periodic maintenance is not covered.

(5) The following equipment is covered, subject to any stated conditions and to the other Program standards, although not Medicare approved:

(a) blanket supports (also known as cradles);

(b) neuromuscular stimulators, if prescribed by an orthopedic or physiatric specialist;

(c) positioning transportation chairs as alternatives to traditional wheelchairs for children 14 years of age and under, who suffer from neuromuscular disorders, closed head injuries, spinal cord disorders or congenital abnormalities;

(d) external electromagnetic bone growth stimulators, as an alternative to bone grafting in cases of severe physical trauma involving non-union of long bone fractures (in excess of 90 days from the date of fracture), or failed bone fusion (stimulators employed in invasive stimulation are excluded under this subsection I.);

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App. A, III. I.3.a.(5)(e)

(e) portable insulin infusion pumps, only when the diagnosis is insulin-dependent type I diabetes mellitus and there is documentation by the physician of poor diabetic control (i.e., widely fluctuating blood sugar before mealtime, frequent episodes of insulin reaction, evidence of frequent ketosis), or insulin-dependent type I diabetes mellitus complicated by pregnancy;

(f) pressure gradient supports (also known as burn pressure garments) prescribed for circulatory insufficiency conditions to promote and restore normal fluid circulation in the extremity (up to four times annually for chronic conditions unless there is a change in physical conditions such as gain or loss of weight of the patient), or when prescribed to enhance healing and prevent scarring of burn patients;

(g) phototherapy (bilirubin) light with photometer, for patients under the age of one having a diagnosis of hyperbilirubinemia;

(h) special features which, although not subject to review and approval under Medicare Part B, are necessary to adapt otherwise covered equipment for use by children; and

(i) continuous passive motion device for use after surgery to the elbow or shoulder (as well as following total knee replacement, as provided by Medicare).

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App. A, III. I.3.a.(6)

(6) Home glucose monitors and related supplies are covered on the same basis as portable insulin infusion pumps above.

Such covered equipment may include special modifications for the sight impaired, as approved under Medicare standards.

(7) Pronged and standard canes must be purchased.

b. Prosthetic and Orthotic Appliances

(1) Unless otherwise indicated below, the appliance must be a prosthetic or orthotic device which meets Program standards. External appliances must be approved for reimbursement under Medicare Part B as of October 1, 1993.

(a) Coverage for therapeutic shoes prescribed for diabetic enrollees not eligible for Medicare shall be limited to the diagnoses established by the Control Plan.

(b) The following items are covered, subject to any stated conditions and to other provisions of the Program and this subsection, although not Medicare-approved:

(i) any style of orthopedic shoe, in addition to a basic oxford, when the shoe is an integral part of a covered brace; and

(ii) all orthopedic shoe inserts, arch supports and shoe modifications used with a shoe that is attached to a covered brace.

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App. A, III. I.3.b.(2)

(2) Coverage is provided for appliances furnished by a fully accredited facility or, with carrier approval, by facilities conditionally accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. as a provider for the kind of device supplied. The following appliances may be provided by facilities not accredited by the American Board for Certification in Orthotics and Prosthetics: ocular prostheses; prescription lenses; pacemakers; ostomy sets and accessories; catheterization equipment and urinary sets; prefabricated custom fitted orthotic appliances; artificial ears, noses, and larynxes; external breast prostheses; and such other appliances as the carrier may determine.

(3) Coverage includes prosthetic appliances or devices which are surgically implanted permanently within the body (except for experimental or research appliances or devices) or those which are used externally while in the hospital as part of regular hospital equipment, as well as external prosthetic or orthotic appliances prescribed by a physician for use outside the hospital.

(4) Coverage for a prosthetic and orthotic appliance includes the replacement, repair, fitting and adjustments of the appliance.

(5) Coverage includes only the first set of prescription lenses (eyeglasses or contact lenses) following a cataract operation for any disease of the eye or to replace the organic lens missing because of congenital absence, or when customarily used during convalescence from eye surgery.

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App. A, III. I.4.

4. Limitations and Exclusions

a. Durable medical equipment which is not covered includes, but is not limited to:

(1) deluxe equipment such as motor driven wheelchairs and beds, unless medically necessary for the treatment of the enrollee's condition and required in order for such enrollee to be able to operate the equipment (for deluxe equipment or features which are not medically necessary for the treatment of the enrollee's condition and required in order for such enrollee to be able to operate the equipment, benefits are limited to the comparable cost of basic, standard equipment);

(2) comfort, convenience, self-help and environmental items not primarily medical in nature such as, but not limited to, bedboards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms, air conditioners, humidifiers, sauna baths, paging systems, intercoms and elevators;

(3) physician's equipment (such as sphygmomanometers and stethoscopes);

(4) exercise and hygienic equipment (such as exercycles, Moore Wheel, bidet, toilet seats and bathtub seats);

(5) experimental, investigational or research equipment; and

(6) home uterine monitoring equipment.

b. Coverage for prosthetic and orthotic appliances does not include:

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App. A, III. I.4.b.(1)

(1) dental appliances; hearin[illegible] ; eyeglasses (except as pro[illegible] in subsection 3.b.(5) above [illegible]uch non-rigid appliances and [illegible]ies as elastic stockings, garte[illegible]ts, corsets or arch supports [illegible] corrective footwear unl[illegible]he footwear is attached to [illegible]edically necessary brace and cov[illegible]ed under subsection 3.b.(1), above;

(2) foot orthotics or any device used to protect the foot from trauma caused by gravitational forces or shoe pressure, whether functional, supportive, accommodative or digital in nature, and whether or not custom-molded;

(3) hair pieces or wigs; or

(4) experimental, investigational or research devices.

J. Hospice Coverage

Hospice coverage, as described below, is available to Basic Medical Plan, Enhanced Medical Plan and Preferred Provider Organization option enrollees. It addresses the needs of terminally ill patients who do not require the continuous level of care provided in a hospital or skilled nursing facility.

1. Definitions

For the purposes of this subsection:

a. "Bereavement counseling" means services provided to the patient's family (or other person caring for the patient at home) after the patient's death.

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App. A, III. J.1.b.

b. "Care rendered in a nursing home facility with hospice support" means care provided to patients who are medically stable but unable to return home because there is no primary care giver available to care for the patient at home, and the patient cannot self-administer the needed care.

c. "Respite care" means short-term inpatient care provided only when necessary to give relief to family members or other persons caring for the patient at home.

2. Conditions of Benefit Payments
An enrollee is eligible for benefits for covered expenses incurred in a hospice program only if the following conditions have been met:

a. The admission to the hospice program commences on or after the effective date and prior to the termination date of the enrollee's coverage in this Program.

b. The services are provided and billed by a hospice program which meets Program standards and is approved by the local carrier.

c. The enrollee is admitted to the hospice program by order of a physician who certifies that the enrollee requires the type of care available through the hospice and that the enrollee has a life expectancy of six months or less.

d. The enrollee voluntarily elects to participate in the hospice program and agrees to accept the services provided by the hospice program as treatment of the terminal condition.

e. The enrollee has benefit period days available under the hospice benefit period (see App. A, II.B.).

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App. A, III. J.3.

3. Coverages

a. Benefits for hospice services are limited to a maximum aggregate lifetime benefit in accordance with Program standard

b. Upon admission to an approved hospice program, an enrollee is entitled to receive the following services when rendered as part of the treatment plan:

(1) nursing care provided by or under the supervision of a registered nurse;

(2) medical social services provided by a social worker under the direction of a physician;

(3) physician services;

(4) counseling services provided to the patient, family members and/or other persons caring for the patient at home;

(5) general inpatient care provided in a hospice inpatient unit;

(6) medical appliances and supplies;

(7) physical, occupational and speech therapies;

(8) continuous home care provided during periods of crisis as necessary to maintain the patient at home;

(9) respite care;

(10) bereavement counseling;

(11) care rendered in a nursing home with hospice support; and

(12) home health aide services.

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App. A, III. K.

K. Case Management Program

1. The Case Management Program (CMP) is a component which is applicable to Basic Medical Plan, Enhanced Medical Plan and Preferred Provider Organization option enrollees, and which is intended to provide high quality, cost-effective alternative treatment options for patients with catastrophic, chronic, and long-term treatment needs which may result in exhaustion of benefits or high costs. It focuses on those whose care could be maintained, improved or prolonged by more effective use of existing Program provisions or, in appropriate cases, through Alternative Benefit Plans designed to cost no more than the treatment otherwise planned. The Case Management Program is not a method for approving new procedures or services not otherwise covered under the Program.

2. The list of conditions used by the carriers for review for potential CMP involvement includes, but is not limited to, the following:

   a. major head trauma;

   b. spinal cord injury;

   c. coma;

   d. multiple amputations;

   e. traumatic and degenerative muscular/neurological disorders (e.g., muscular dystrophy, "Lou Gehrig's Disease," multiple sclerosis);

   f. newborns with high risk complications;

   g. births with multiple congenital anomalies;

   h. cerebrovascular accident (stroke) requiring long-term rehabilitation;

   i. severe burns;

   j. Acquired Immune Deficiency Syndrome (AIDS);

   k. selected blood abnormalities;

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App. A, III. K.2.1.

l. diagnoses involving long-term IV therapy (e.g., osteomyelitis, pericarditis, endocarditis);

m. severe rheumatoid arthritis;

n. selected osteoarthritis;

o. Crohn's disease; and

p. cases involving extended or repeated hospital stays, as well as cases having multiple admissions for the same diagnosis.

3. Once a patient's medical condition is identified by the carrier as having potential for case management, the case is reviewed confidentially, and a treatment plan may be developed by the carrier with the cooperation of the patient, family, and the physicians/providers.

4. If a decision is made to implement a treatment plan that incorporates services not otherwise covered under this Program (an Alternative Benefit Plan), the remaining days of inpatient care, determined in accordance with the attending physician's prognosis, are converted into a dollar pool against which all benefits paid while the patient is under the Alternative Benefit Plan are charged.

a. The total cost of Alternative Benefit Plans involving services not otherwise covered will be limited by the cost of treatment which would have occurred otherwise.

b. If the dollar pool is exhausted, the Alternative Benefit Plan ceases and the provisions of Appendix A, II.B. will apply with regard to renewal of a benefit period.

c. Participation in the Case Management Program is voluntary, and the patient may withdraw from an Alternative Benefit Plan at any time. In such event, the remaining dollar pool is reconverted to equivalent hospital days to determine the patient's entitlement, if any, remaining in the benefit period.

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App. A, IV.

IV. Limitations and Exclusions

In addition to the limitations and exclusions appearing in other Sections of this Appendix, the following general limitations and exclusions apply to all Sections:

A. Effective date: For the purposes of this Section, effective date means the later of the effective date of this Program or the effective date of the enrollee's coverage under this Program. Benefits are not provided under this Program for:

1. services, treatment, or care provided to an enrollee prior to the effective date; or

2. hospital, skilled nursing facility, or home health care services for admissions which commenced prior to the effective date.

B. Termination date: Coverage is not provided for services provided after the date this Program or an enrollee's coverage under this Program is terminated except that the coverage continues for physician and hospital, skilled nursing facility, or residential substance abuse facility services for continuous predetermined and approved (see App. A, II.A. and App. B, II.A.) inpatient admissions which commenced prior to the termination date of such coverage.

C. Excluded facilities: Coverage under this Appendix does not include services provided by a day or night care program, a halfway house, group home, adult foster care facility, health club or the like.

D. Private duty nursing services: Coverage under this Appendix does not include services of private duty nurses.

E. Room accommodations: If accommodations more expensive than those specified in Section III.A. are used for any reason, the carrier will not pay the difference between the charges for the more expensive accommodations and those for the covered accommodations. If, for any reason, the enrollee occupies accommodations less expensive than those covered by this Appendix, the enrollee is not entitled to payment of the difference in charges.

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App. A, IV. F.

F. Dental services: Coverage does not include d tal services except as specifically provided for this Appendix.

G. Temporomandibular joint (TMJ) dysfunction: ge age under this Appendix for diagnosis and treat nt of TMJ dysfunction is limited to diagnostic exami tions and imaging, surgery to the joint (including r lated facility charges) and medically necessary post-surgical physical therapy services.

H. Chemotherapy: Coverage does not include chemotherapy services or supplies (chemotherapeutic antineoplastic agents and their administration) when the treatment is research, investigational or experimental in nature or when not specifically provided for in this Appendix.

I. Medical necessity: Coverage does not include services, care, treatment, or supplies which are not medically necessary according to accepted standards of medical practice in the United States for the treatment of any condition, injury, disease, or pregnancy, except as specifically provided for in this Appendix (e.g., voluntary sterilizations). Determinations of the Control Plan as to medical necessity and the accepted standards of medical practice are based on factors which include, but are not limited to: scientific data (such as reported controlled studies); information from local and national medical, professional and insurance societies, organizations, committees and bodies; and approvals and policies of the Food and Drug Administration, the Department of Health and Human Services and other Federal agencies. The Control Plan shall have discretionary authority to interpret, apply and construe this provision of the Program. The Control Plan's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious

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App. A, IV. J.

J. Research, investigational or experimental services: Coverage does not include care, services, supplies, or devices ("procedures") which, as determined by the Control Plan, are experimental, research or investigational in nature (i.e., ones, which in the judgment of the Control Plan, have not been demonstrated scientifically to be both effective and safe in the treatment of the patient's condition). This exclusion applies to facility and professional services directly related to non-covered experimental, research or investigational procedures. However, if the Control Plan determines that hospitalization is medically necessary and appropriate in order for such non-covered procedure to be performed safely, routine hospital and professional services not related directly to such non-covered procedure may be covered. The Control Plan is responsible for determining whether a procedure is experimental, research or investigational in nature based on factors which include, but are not limited to: the existence of an experimental, research or investigational plan or protocol; the necessity for written informed consent used by the treating physician (which may or may not include a reference to the procedure being research, investigational, experimental or other than conventional in nature); existence of ongoing clinical trials; scientific data such as controlled studies which are reported in medical literature; approvals and policies of Federal agencies; and information from professional groups. The Control Plan shall have discretionary authority to interpret, construe and apply this provision of the Program. The Control Plan's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

Procedures, services, supplies, drugs, products, applications of the above and other items which are considered to be experimental, research or investigational are evolutionary in nature. The Control Plan is responsible for maintaining current information on items which have been so identified for purposes of claims adjudication, and such information is incorporated herein by reference.

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App. A, IV. J.

The fact that a procedure, service, supply, drug, product, etc., is not so identified shall not in any way infer that it is not experimental, research or investigational in nature. The information is intended to be illustrative rather than exhaustive.

Enrollees and/or providers having questions about the status of items may obtain Control Plan assistance in resolving the questions.

At the point in time when the Control Plan determines a procedure previously identified as experimental, research or investigational has become standard medically accepted practice in the United States, the Control Plan will make a recommendation to the Corporation under the procedure for approval of new services (see App. A, II.I.). If the Control Plan's recommendation is adopted (in its entirety or with modifications), an effective date will be assigned and coverage will be provided on and after that date. If the Control Plan's recommendation is rejected, the procedure will be identified as a specific Program exclusion.

K. Personal or convenience items: Coverage does not include care, services, supplies, or devices which are personal or convenience items. Examples include, but are not limited to, television/telephone rental, guest meals and the like.

L. Services not related to specific diagnosed illness or injury: Coverage does not include services for premarital examinations or pre-employment examinations.

M. Unreasonable charges: Coverage does not include any charges to the extent such charges are determined by the carrier to be unreasonable.

N. Employer related services: Coverage does not include services related to any condition, disease, ailment, or injury arising out of or in the course of employment and for which the employer furnishes, pays for, or provides reimbursement under the provisions of any law of the United States or any state or political

subdivision thereof, or for which the employer makes a settlement payment. Coverage does not include services rendered through a medical clinic or other similar facility provided or maintained by an employer.

O. Services available without cost: Coverage does not include services for which a charge would not have been made if no coverage existed; services for which the enrollee is not legally obligated to pay; or services which the enrollee received or, upon application, could receive without cost under the laws or regulations of the United States of America, Dominion of Canada, any other country, or any state or political subdivision thereof.

P. Services available through other programs: Coverage does not include any service to the extent the benefits are payable:

1. Under any group health care contract under the coordination of benefits provision of this Program;

2. Under Medicare, if the enrollee was or would have been eligible for Medicare benefits at the time of service had the enrollee enrolled in Medicare (see App. A, II.E.); or

3. Under any health care program supported in whole or in part by funds of the Federal government or any state or political subdivision except where by law this Program is made primary.

Q. Services provided by family members or relatives: Coverage does not include services provided to the enrollee by members of the enrollee's household or immediate relatives of the enrollee. For purposes of this provision, "immediate relative" refers to the enrollee's spouse, natural or adoptive parents, children or siblings, step-parents, -children or -siblings, father-, mother-, son-, daughter-, brother- or sister-in-law, and grandparents or grandchildren of the enrollee or the enrollee's spouse.

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App. A, IV. R.

R. Custodial or domiciliary care: Coverage ...e not include care, services, supplies or devi... ...elated to custodial or domiciliary care provided i... a institutional setting (e.g. - hospital, ...ing facility) except as provided under the ... health care and hospice provisions of this Ap... ...x (App. A, III.D. and III.J., respectively).

S. Inducement of pregnancy: Coverage does not include care, services, supplies, drugs or devices which are provided for the purpose of inducing pregnancy.

T. Travel: Coverage does not include travel time or expenses.

U. Education: Coverage does not include special education facilities and tutoring for learning disabilities or correction of behavioral problems.

V. Food and dietary supplements: Coverage does not include food/dietary supplements or vitamins.

W. Physician requirements: Coverage does not include services, supplies or equipment not performed by, prescribed by or rendered by a physician.

X. Miscellaneous services: Coverage does not include charges for acupuncture, massage, Christian Science services, hypnotherapy, neurotherapy, or biofeedback therapy or services.

Y. Provider administrative charges: Coverage does not include charges for missed appointments, room or facility reservations or the completion of any claim forms or record processing.

Z. Bone marrow transplants:

1. Allogeneic bone marrow harvesting/transplants

a. Facility and physician services are covered when related to allogeneic bone marrow harvesting and transplants performed to treat the following conditions:

App. A, IV. Z.1.a.(1)

(1) aplastic anemia;
(2) acute lymphocytic and non-lymphocytic leukemia;
(3) chronic myeloid leukemia;
(4) severe combined immune deficiency disease (SCID);
(5) Wiskott-Aldrich syndrome;
(6) osteopetrosis;
(7) beta thalassemia, major;
(8) neuroblastoma (stage III or IV);
(9) Hodgkins disease (stage III or IV);
(10) non-Hodgkins lymphoma (intermediate or high grade);
(11) Hurler's syndrome; and
(12) myelodysplastic syndromes.

b. Bone marrow transplants are covered when the donor is a first degree relative and has either the same genetic (i.e., human leukocyte antigen or HLA) markers (six out of the six important genetic markers) or five out of the six important genetic markers as the person receiving the transplant. When only five out of the six genetic markers match, the mixed lymphocyte culture (MLC) must be negative.

c. Also included as covered services are:

(1) bone marrow transplants when the donor is not a first degree relative and has the same six important genetic markers as the person receiving the transplant;

(2) blood tests on relatives for evaluation as donors, if the tests are not covered by the potential donor's health care coverage;

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App. A, IV. Z.1.c.(3)

(3) harvesting of marrow, if no covered by the donor's health care co age, when the donor is:

(a) a first degree relat e with no less than five out the six important genetic m kers as the person receiving t transplant; or

(b) a person other than a first degree relative with the same six out of six important genetic markers as the person receiving the transplant;

(4) search of the National Donor Marrow Program Registry for a donor, and harvesting and transportation of marrow, when the donor is:

(a) a first degree relative with no less than five out of the six important genetic markers as the person receiving the transplant; or

(b) a person other than a first degree relative with the same six out of six important genetic markers as the person receiving the transplant;

provided the Registry's bill must be submitted to the carrier by the bone marrow transplant center.

2. Autologous bone marrow/peripheral tem cell harvesting/transplants

Facility and physician services ar overed when related to autologous bone marrow/p ipheral stem cell harvesting and transplants per med for the following conditions:

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App. A, IV. Z.2.a.

a. Hodgkins disease (stage III or IV);

b. non-Hodgkins lymphoma (intermediate or high grade);

c. neuroblastoma (stage III or IV);

d. acute lymphocytic and non-lymphocytic leukemia; and

e. germ cell tumors of ovary, testis, mediastinum or retroperitoneum.

3. Non-covered expenses

Facility and physician services and other charges directly relating to bone marrow transplants other than those identified in subsections Z.1. and Z.2., above, are excluded. Excluded services and charges include, but are not limited to:

a. bone marrow transplants when the donor is a first degree relative and has less than five out of six genetic markers as the person receiving the transplant;

b. bone marrow transplants when the donor is not a first degree relative and has less than six out of six genetic markers as the person receiving the transplant;

c. autologous bone marrow and/or peripheral stem cell and/or allogeneic bone marrow harvest and transplants for solid tumors other than shown in 1. and 2. above, which include, but are not limited to:

(1) breast;
(2) colon;
(3) lung;
(4) brain; or
(5) skin;

d. allogeneic bone marrow transplants from non-HLA identical donors;

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App. A, IV. Z.3.e.

e. autologous or allogeneic bone marrow transplants for patients with multiple myeloma (whether or not the donor is HLA-identical);

f. search of the National Donor Marrow Program Registry for a donor, other than a first degree relative, with fewer than six out of six important genetic markers as the person receiving the transplant;

g. bone marrow harvesting, storage, transportation or transplantation from a person, other than a first degree relative, with fewer than six out of six important genetic markers as the person receiving the transplant;

h. purging or positive stem cell selection of the bone marrow or peripheral stem cell collection; and

i. travel expenses of patients (other than ambulance services which may be covered under App. A, III.F., in appropriate cases) and family members.

AA. Cochlear implant: Coverage under this Appendix, for services related to the implantation of a cochlear hearing device, is subject to Program standards regarding patient selection, covered pre-surgical, surgical and post-surgical services and covered devices, as well as to a lifetime maximum of one device/implantation for each enrollee satisfying the patient selection criteria.

App. B

APPENDIX B

MENTAL HEALTH AND SUBSTANCE ABUSE COVERAGE

The provisions of this Appendix B apply to enrollees of the Basic Medical Plan, Enhanced Medical Plan and Preferred Provider Organization options of the Program.

I. Definitions
To the extent they are not in conflict with the following, definitions in Appendix A are incorporated herein by reference. For purposes of this Appendix:

A. "approved mental health or substance abuse treatment program and/or provider" means an inpatient or outpatient program and/or provider which/who provides medical and other services to enrollees for a mental health or substance abuse condition, meets all state licensure and approval requirements, and has entered into an agreement with the coverage carrier to provide services as specified in this Appendix.

B. "assessment" means

1. determination by an assessment coordinator of the nature of the enrollee's condition (mental health and/or substance abuse), the need for treatment, the type of treatment required and referral to the most appropriate level of care; and

2. for a substance abuse patient, the development of a continuing care treatment plan by the enrollee, the assessment coordinator, and the attending physician, if appropriate.

C. "assessment coordinator" means a qualified employee of a central diagnostic and referral agency (CDR) which has been selected and approved to provide assessment services. Assessment coordinators must meet Program standards for selection.

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App. B, I. D.

D. "central diagnostic and referral agency" or "CDR" means an approved agency which employs assessment coordinators designated to: make all contractually-mandated face-to-face assessments for the development of substance abuse continuing care treatment plans; make determinations regarding whether the patient's condition requires mental health and/or substance abuse treatment; make referrals to panel providers; provide short-term counseling (up to two visits per enrollee); and perform aftercare planning and follow-up. The CDR may provide up to three short-term counseling sessions for employees, and may communicate with Employee Assistance Program representatives about assessment and referral activities relating to an employee (when appropriate and when authorized by the employee). The CDR will supply necessary information to the carrier about panel provider performance and selection and other utilization data and statistics as required, including evaluations using designated performance data of panel providers with whom the carrier contracts.

E. "central review organization" or "CRO" means a national organization which has been designated to provide the following functions: confirm eligibility of the patient for mental health and/or substance abuse coverage under the Program; authorize and approve inpatient and outpatient mental health treatment, outpatient substance abuse treatment and outpatient psychological testing; exercise managed care protocols, with CDR assistance when appropriate, for those enrollees who require both mental health and substance abuse outpatient visits; and evaluate panel providers and give input to the carrier, using designated performance standards.

F. "clinical nurse specialist" means a person who meets all of the following criteria:

1. possesses a Master of Arts (MA), Master of Science (MS) or Master of Science in Nursing (MSN) degree from an accredited school of nursing. (The master's degree must be in

App. B, I. F.1.

psychiatric nursing or the individual must be eligible for listing in the American Nursing Association Register of Certified Nurses in Advanced Practice as a clinical specialist in: Adult Psychiatric Mental Health Nursing, or Child/Adolescent Psychiatric Nursing);

2. has a minimum of five years post-master's degree clinical experience in the field of psychiatric mental health nursing, at least two of which were supervised by a master's level psychiatric nurse (or the equivalent);

3. possesses a license as a Registered Nurse in the jurisdiction in which the practice is to occur;

4. possesses a minimum professional liability coverage of $1 million per occurrence and $1 million aggregate (unless there are state statutes which modify the malpractice requirements in such states); and

5. has signed an agreement with the carrier to participate as a panel provider.

G. "continuing care treatment plan" means a document completed for substance abuse patients by an assessment coordinator at the conclusion of the assessment process. The continuing care treatment plan includes the recommended provider(s), and the type(s) and duration of treatment, and may be modified by the provider and the assessment coordinator in consultation during the course of treatment.

H. "day treatment" and "night treatment" mean the treatment of patients with mental health or substance abuse disorders who spend only part of a 24-hour period in a facility, and who undergo therapy for more than four hours a day. Day care patients reside in the community and go to the facility for each day of treatment. Night care patients remain in the community during the day, but sleep at the facility where they are provided bed, board, and treatment.

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App. B, I. I.

I. "detoxification" means treatment for the physiologic stabilization of an enrollee who is undergoing acute withdrawal from an intoxicating substance. To be covered under this Program, such treatment must be provided by, or under the supervision of, a physician and through a facility approved to provide such care.

J. "detoxification facility" means a hospital or residential treatment facility which is a provider of detoxification services. Such facilities may offer substance abuse rehabilitation treatment subsequent to detoxifying an enrollee.

K. "halfway house treatment" means treatment provided under a semi-residential living arrangement to a substance abuse patient who requires a more structured living environment than outpatient treatment or day or night treatment would provide, but who does not require full-time residential treatment and care. It provides a controlled environment during the hours of the day the enrollee is not undergoing treatment or is not engaged in specific constructive activity (e.g., working, attending school).

L. "inpatient care" means treatment in:

1. a hospital;

2. a detoxification facility; and

3. a residential care facility.

M. "mental disorder" means any mental, emotional, or personality disorder classified as a mental disorder in categories 290.0 through 319.0 of the most recent edition of the "International Classification of Diseases, 9th Revision, Clinical Modification" excluding alcohol and drug abuse as classified in categories 303.0 through 305.9 (see subsection IV.H., below).

N. "outpatient facility" means an administratively distinct governmental, other public, private, or independent unit or part of such unit that provides outpatient mental health or substance abuse services.

App. B, I. N.

The term includes centers for the care of adults or children such as hospitals, clinics, and day or night treatment centers. For mental health services, the definition includes Community Mental Health Centers as defined in the Federal Community Mental Health Centers Act of 1963, as amended.

O. "outpatient treatment" or "visit" means a therapy session provided in an outpatient mental health or substance abuse treatment facility or by an individual mental health or substance abuse provider. All sessions between an individual patient and a provider in a single day, with a total duration of four hours or less, are considered to be a single treatment or visit. If outpatient sessions with all providers in a given day total more than four hours, such treatment shall be considered day or night treatment.

P. "panel provider" means a mental health or substance abuse provider who has been selected and has agreed to provide services in accordance with the terms of participation established by the Program and has executed an agreement with the carrier.

Q. "psychiatrist" means a physician who is board eligible or board certified in psychiatry and licensed to practice medicine at the time and place services are rendered or performed.

R. "psychologist" means a person who possesses a doctor of philosophy (Ph.D.), doctor of education (Ed.D.), doctor of mental health (DMH.), or doctor of psychology (PsyD.) degree from a regionally accredited university, has a minimum of five years of post-doctoral clinical experience (at least two of which were supervised by a licensed clinical psychologist or by a board-qualified psychiatrist), possesses a valid license for the independent practice of psychology at the highest level recognized by the state in which practice is to occur, is eligible for listing in the National Register of Health Care Providers in Psychology, and participates as a panel provider.

App. B, I. S.

S. "registration" means contact by the provider with the CRO to inform the agency that the enrollee is commencing a course of mental health or substance abuse treatment, to confirm eligibility under the Program, and to obtain any necessary approvals or authorizations.

T. "residential care facility" means an approved inpatient facility which operates 24 hours a day, seven days a week for the provision of residential mental health and/or substance abuse treatment.

U. "social worker" means a person who possesses a master in social work (MSW), master of science in social work (MSSW), or doctor of social work (DSW) degree from a graduate school of social work accredited by the Council on Social Work Education, has a minimum of five years of post-masters or post-doctoral degree clinical social work experience (at least two of which were supervised by a licensed clinical social worker), possesses a valid license or certificate for the independent practice of social work at the highest level recognized by the state in which practice is to occur, is eligible for listing in the National Association of Social Work Register of Clinical Social Workers and/or the National Register of Mental Health Care Providers in Social Work, and participates as a panel provider.

V. "substance abuse" means alcohol or drug dependence as classified in categories 303.0 through 305.9 (excluding 305.1 and 305.9) of the most current edition of the "International Classification of Diseases, 9th Revision, Clinical Modification" (see subsection IV.H., below).

II. Terms and Conditions of Coverage

A. Conditions of Benefit Payment
An enrollee is eligible for benefits for covered expenses incurred during an approved course of treatment only if the following conditions or requirements are met:

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App. B, II. A.1.

1. Services must be provided, or admissions must commence, on or after the enrollee's effective date of coverage under the Program and this Appendix.

2. Benefits must be available within the benefit period (see II.B., below).

3. a. In order to be covered up to the benefit maximum under the Program, all covered services rendered in the care and treatment of mental health and substance abuse related disorders must be delivered by panel providers, except in the case of emergency which is subject to the provisions of Section IV.B. of this Appendix. The panel may be comprised of the following types of facilities and providers:

(1) Hospitals
(2) Outpatient facilities
(3) Detoxification facilities
(4) Residential care facilities
(5) Day and night care facilities
(6) Halfway houses
(7) Skilled nursing facilities
(8) Psychiatrists
(9) Psychologists
(10) Social workers
(11) Clinical nurse specialists

b. In addition, if due to the unavailability of specialized services, the enrollee must be referred to a non-panel provider, then, in such cases only, non-panel providers will be covered up to the benefit maximum subject to App. B, II.B.4.a. and b., provided the enrollee is referred by a panel provider and the services are authorized, in advance, by the CRO.

c. Services provided in accordance with App. B, IV.B.3. are covered up to the benefit maximum.

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App. B, II. A.4.

4. Outpatient treatment by social workers or psychologists as independent practitioners must be rendered by participating panel providers.

5. In order to be eligible for benefits for residential and/or halfway house substance abuse treatment, the enrollee must be assessed by an assessment coordinator from a designated CDR. Expenses for days of treatment during an admission to a residential treatment facility or halfway house program will not be covered prior to the time assessment and a treatment plan are obtained from a substance abuse assessment coordinator. If such coordinator makes a determination of substance abuse and the assessment specifies a level of care which includes residential or halfway house treatment, such treatment will be covered subject to other Program provisions.

6. Detoxification admissions must be reported to the CRO within 24 hours of admission. In such cases, the CRO will notify the CDR assigned to that location. The CDR's assessment coordinator will contact the enrollee during or after the detoxification and develop a plan for treatment subsequent to detoxification (continuing care treatment plan). Detoxification confinements longer than three days must be approved by the CDR or CRO.

7. Mental health inpatient services and admissions must be authorized by the CRO within 24 hours of admission.

8. Day or night treatment and outpatient mental health and substance abuse treatment must be registered with the CRO. This procedure does not apply to day, night or outpatient treatment services rendered as part of an authorized substance abuse continuing care treatment plan.

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App. B, II. A.9.

9. Admission to a skilled nursing facility must be for the treatment of a mental health condition, must be authorized by the CRO and must immediately follow a confinement for the same condition.

10. Benefits are payable subject to the provisions and limitations of the Program, regardless of the treatment plan developed through assessment.

11. Benefits payable under this Appendix for an enrollee eligible for Medicare shall be paid in accordance with the terms and conditions pertaining to Medicare as specified in App. A, II.E.

B. Benefit Period

1. a. An enrollee is eligible for a maximum of 45 days of covered inpatient mental health care within the benefit period set forth in App. A, II.B.1.

b. An enrollee is eligible for a maximum of 45 days of covered inpatient substance abuse care including detoxification within the benefit period set forth in App. A, II.B.1.

c. Each day of care utilized for inpatient substance abuse treatment is charged against the unused portion of the 45-day inpatient mental health benefit period. Likewise, each day of inpatient mental health care is charged against the unused portion of the 45-day inpatient substance abuse treatment period.

2. a. An enrollee is eligible for a maximum of 90 days of care in a day or night treatment facility within the benefit period set forth in App. A, II.B.1.

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App. B, II. B.2.b.

b. Each day of inpatient care for me a[illegible] health or substance abuse treatme[illegible] reduces by two the number of day[illegible] care available for mental health or s[illegible] abuse day or night treatment. E[illegible] two days of day or night treatment [illegible]ces by one the number of days of care [illegible]lable for inpatient care.

3. a. An enrollee is eligible for a [illegible]ximum of 90 days of mental health care [illegible]n an approved skilled nursing facility within the benefit period set forth in App. A, II.B.1.

b. Each day of inpatient care for mental health treatment within the benefit period reduces by two the number of available days for skilled nursing facility care. Each two days of medical care for the treatment of mental disorders in a skilled nursing facility reduces by one the number of days of inpatient medical care available for the treatment of mental health related disorders in a hospital.

4. a. An enrollee is eligible for 20 outpatient mental health visits at 100% coverage and an additional 15 visits at 75% coverage for outpatient mental health treatment for both facility and professional services per calendar year.

b. An enrollee is eligible for 35 outpatient substance abuse visits at 100% coverage for both facility and professional services per calendar year.

c. When an enrollee requires mental health and/or substance abuse outpat[illegible]ent treatment, the CRO and/or CDI where appropriate) shall exercise m[illegible]aged care protocols after a total of six [illegible]utpatient visits and shall monitor the t[illegible]atment plan(s) to assure appropriate [illegible]ordinated care.

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App. B, II. B.4.c.(1)

(1) Inpatient substance abuse care assessments, referrals and continuing care treatment follow-up by CDRs are mandatory and do not reduce the enrollee's outpatient visit entitlement.

(2) Voluntary utilization of the CDR for outpatient mental health or substance abuse assessment and referral does not count as an outpatient visit.

d. Anorexia nervosa, bulimia and other conditions covered by Appendix B which are appropriate for case management, may be case managed by the CRO utilizing the case management procedures described in App. A, III.K. with any alternative benefit plan being limited to the dollar pool created using the 45-day inpatient benefit described in this section.

e. Outpatient psychological testing is not considered "treatment" and is not charged against the outpatient visit maximum.

f. Each visit by one or more members of an enrollee's family for family counseling counts as one visit applicable to the enrollee's annual outpatient treatment maximum.

5. An enrollee shall be eligible for a lifetime maximum of 90 days of substance abuse treatment in a panel halfway house.

6. A new benefit period begins only when the enrollee has been out of care (as described below) for a continuous period of 60 days. Accordingly, there must be a lapse of at least 60 consecutive days between the date of the enrollee's last discharge from any hospital, skilled nursing facility, residential care facility or any other facility to which the 60-day benefit renewal period of this Appendix and Appendix A apply (see App. A, II.B.3. for example), and the date of the next admission,

App. B, II. B.6.

irrespective of the reason for the last admission and irrespective of whether or ɔt benefits are paid as a consequence of suc admission. Further, if subsequent to su: discharge, the enrollee is a patient in psychiatric or substance abuse day or n .t care program, a substance abuse halfwa; nouse, a hospice program or is receiving home nealth care visits, the 60-day renewal period is broken, whether or not benefits are paid as a result of receipt of such services.

C. Non-Completion of the Substance Abuse Treatment Plan by an Employee

Employees entering detoxification, residential or halfway house treatment facilities are required to receive a continuing care treatment plan from the assessment coordinator as part of the assessment process. Non-completion of the portions of such treatment plan which are covered services (including outpatient and day or night programs) will result in the following actions being taken:

1. The carrier will send a letter to the employee and to the appropriate GM Medical Director notifying them of the failure to complete the treatment plan.

2. The letter will notify the employee that if a second continuing care treatment plan is established and not completed, a maximum of up to a $500 overpayment will have occurred as a result of medical expenses incurred on the employee's behalf.

3. If the employee fails to complete a second continuing care treatment plan, the carrier will notify the employee and the GM Medical Director of such failure and of any overpayment. The provisions of Article I, Section 9, of the Program will apply.

App. B, II. C.3.

However, if the employee establishes to the satisfaction of the GM Medical Director that such employee is motivated towards recovery and that the treatment plan was discontinued for a satisfactory reason, then such overpayment will not have occurred.

4. For each subsequent non-completion of a treatment plan, the maximum overpayment amount will increase in increments of $250, up to a maximum overpayment amount of $1,000 for each occurrence.

III. Coverages

A. Inpatient Care (Mental Health and Substance Abuse)

1. Inpatient mental health and substance abuse care is subject to the benefit period set forth in App. B, II.B.1.

2. Inpatient services by non-panel providers are subject to the provisions of Sections IV.B.2. (for mental health treatment) and IV.B.4. (for substance abuse treatment) of this Appendix.

3. Coverage includes the following inpatient services when provided and billed by the facility:

a. semiprivate room, including general nursing services, meals and special diets;

b. laboratory and pathology examinations related to the treatment received in the facility;

c. drugs, biologicals, solutions and supplies related to the treatment received and used while the enrollee is in the facility;

d. supplies and use of equipment required in the care and treatment of the enrollee's condition;

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App. B, III. A.3.e.

e. professional and ancillary servi es, including those of other trained staff, necessary for patient care and ·-tment, including diagnostic examinati·

f. individual and group therapy;

g. counseling for family member.;

h. electroshock therapy for a mental health patient, when administered by, or under the supervision of, a physician and anesthesia for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy; and

i. supplies and use of equipment required for detoxification or rehabilitation of substance abuse patients.

4. Psychological testing is covered when administered by a panel psychologist, medically indicated, approved by the CRO and directly related to the organic medical or functional condition or when it has an integral role in rehabilitative or psychiatric treatment programs.

5. Coverage for medical care for the treatment of mental disorders is limited to (i) individual psychotherapeutic treatment, (ii) family counseling for the enrollee's family, (iii) group psychotherapeutic treatment, (iv) psychological testing when prescribed or performed by a physician, and (v) electroshock therapy and anesthesia for electroshock therapy.

B. Skilled Nursing Facility Care (Mental Health Only)

1. Mental health care in a skilled nursing facility is subject to the benefit period set forth in App. B, II.B.3.

2. Coverage includes services as described in A.3., above, and medical care. Medical care in a skilled nursing facility is limited to a maximum of two physician visits per week.

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App. B, III. C.

C. Halfway House Care (Substance Abuse Only)

1. Substance abuse care in a halfway house is subject to the benefit maximum set forth in App. B, II.B.5.

2. Coverage includes the following halfway house services when provided and billed by the facility:

a. bed and board;

b. intake evaluation;

c. up to one routine drug screen per week;

d. individual and group therapy or counseling; and

e. counseling for family members.

D. Day or Night Care (Mental Health and Substance Abuse)

1. Mental health and substance abuse care in day or night care treatment facilities is subject to the benefit period set forth in App. B, II.B.2.

2. Inpatient services by non-panel providers are subject to the provisions of Sections IV.B.2. (for mental health treatment) and IV.B.4. (for substance abuse treatment) of this Appendix.

3. Coverage for treatment in a day or night care treatment facility includes the following services when provided and billed by the facility:

a. laboratory examinations related to the treatment received in the facility;

b. prescribed drugs, biologicals, solutions and supplies related to the treatment received, including, for substance abuse, drugs to be taken home;

App. B, III. D.3.c.

c. supplies and use of equipment required in the care of the enrollee's condition;

d. professional and ancillary service including those of other trained staff, necessary for the treatment of ambulatory enrollees, including diagnostic examinations;

e. individual and group therapy;

f. psychological testing;

g. counseling for family members;

h. electroshock therapy for a mental health patient when administered by, or under the supervision of, a physician and anesthesia for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy; and

i. an enrollee admitted to night care treatment also is entitled to a semiprivate room, general nursing services, meals and special diets.

E. Outpatient Care (Mental Health and Substance Abuse)

1. Outpatient mental health and substance abuse treatment is subject to the benefit maximums set forth in App. B, II.B.4.a. and b.

2. Covered outpatient mental health and substance abuse treatment includes the following:

a. Services provided and billed by facilities

(1) professional and other staff and ancillary services made available by facilities to ambulatory patients;

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App. B, III. E.2.a.(2)

(2) prescribed drugs and medications dispensed by a facility in connection with treatment received at the facility; and

(3) electroshock therapy for a mental health patient, when administered by, or under the supervision of, a physician and anesthesia for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy.

b. Services provided and billed by facilities or professional providers

(1) Individual psychotherapeutic treatments of a duration of 20 minutes or more (all sessions with a given provider on a single day, with a total duration of four hours or less, shall constitute a single "visit" and be reimbursed as a single unit of service).

(a) Benefits will be paid as set forth in App. B, II.B.4.a. for outpatient mental health services at 100% of the panel reimbursement amount for the first 20 outpatient mental health treatments and 75% for the next 15 treatments per calendar year when provided by panel providers. Services rendered by non-panel providers as provided in App. B, II.A.3.b. and in App. B, IV.B.3. shall be covered up to the benefit maximums. Otherwise, when outpatient mental health services are received from a

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App. B, III. E.2.b.(1)(a)

non-panel provider, without referral by the CRO, such services must be rendered by qualified physicians qualified facilities, and will be reimbursed at 50% of the amount payable to panel providers for comparable services. Such reimbursement will be made only to the primary enrollee.

(b) Benefits will be paid as set forth in App. B, II.B.4.b. for individual outpatient substance abuse treatment at 100% of the panel reimbursement amount for 35 visits per calendar year when provided by panel providers. No benefits are payable for treatment by non-panel providers, except when services are rendered by non-panel providers as provided in App. B, II.A.3.b. in which case such treatment shall be covered up to the benefit maximum.

(2) Group mental health and substance abuse treatment is covered subject to the payment provisions in subsections (a) or (b) above.

(3) Family counseling to members of the patient's family is covered subject to the payment provisions in subsections (a) or (b) above.

3. Outpatient psychological testing is covered only when preauthorized by the CRO and performed by a panel provider. Such testing is not considered treatment and therefore is not subject to the benefit period maximum.

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App. B, IV.

IV. Limitations and Exclusions

A. Panel providers are required to contact the CRO to verify eligibility and receive prior authorization of all non-emergency inpatient and outpatient mental health and substance abuse services.

B. Coverage will be limited to the following when rendered by or through non-panel providers:

1. Emergency services. Providers must contact the CRO within 24 hours of the inpatient admission or outpatient treatment for authorization of such services.

2. Non-emergency services. Benefits for mental health services provided by qualified physicians or facilities who/which are non-panel providers are limited to 50% of the panel reimbursement amount unless the enrollee is referred to the non-panel physician or facility by a panel provider. The carrier will make payment to the primary enrollee. Payment to the provider, including any balance, is the responsibility of the enrollee.

3. Outpatient services. Services provided by non-panel physicians (e.g., internists or general practitioners) must be registered with the CRO after the first visit and are limited to a maximum of one visit.

4. Substance abuse treatment. Coverage for substance abuse treatment does not include services provided by non-panel providers except for emergency detoxification.

C. Coverage is not available for services for treatment of mental disorders which, according to generally accepted medical standards (as determined by the carrier), are not amenable to favorable modification, except that coverage is available for the period necessary to determine that the disorder is not amenable to favorable modification, or for the period necessary for the evaluation and diagnosis of mental deficiency or retardation.

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App. B, IV. D.

D. Coverage for substance abuse treatment does not include professional services such as dispensing methadone, testing urine specimens, or performing physical or x-ray examinations or other diagnostic procedures unless therapy, counseling or psychological testing are provided on the same day.

E. Coverage does not include family counseling which is rendered by a provider other than the provider for the family member in the course of treatment. Furthermore, reimbursement will be provided only in conjunction with services rendered on behalf of enrollees covered under the General Motors Health Care Program.

F. Coverage does not include diversional therapy.

G. Coverage does not include psychological testing if used as part of, or in connection with, vocational guidance, training or counseling.

H. Coverage under this Appendix does not include treatment of tobacco use disorder (ICD-9 Code 305.1) or treatment of non-dependent abuse of substances such as laxatives, patent medicinals, etc. (ICD-9 Code 305.9).

I. General Limitations and Exclusions under Section IV. and subsections II.C., E., G., and H. of the Terms and Conditions of Appendix A are equally applicable under this Appendix.

SALARIED HEALTH CARE PROGRAM

App. C.

APPENDIX C

DENTAL COVERAGE

I. Enrollment Classifications

Dental coverage for a primary enrollee may include coverage for eligible secondary enrollees as defined in the Program.

II. Description of Benefits

Dental benefits will be payable, subject to the conditions herein, if an enrollee incurs a covered dental expense.

III. Covered Dental Expenses

Covered dental expenses are the usual charges of a dentist which an enrollee is required to pay for services and supplies which are necessary for treatment of a dental condition, but only to the extent that such charges are reasonable and customary charges, as herein defined, for services and supplies customarily employed for treatment of that condition, and only if rendered in accordance with accepted standards of dental practice. Such expenses shall be only those incurred in connection with the following dental services which are performed, except as otherwise provided in Section VII.B., by a licensed dentist and which are received while coverage is in force.

A. The following covered dental expenses shall be paid at 100% of the reasonable and customary charge:

1. Routine oral examinations and prophylaxes (scaling and cleaning of teeth), but not more than twice each in any calendar year (three prophylaxes per calendar year will be allowed if there is a documented history of periodontal disease).

2. Topical application of fluoride provided that such treatment shall be a covered dental expense only for enrollees under 20 years of age, unless a specific dental condition makes such treatment necessary.

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App. C, III. A.3.

3. Space maintainers that replace prema rely lost teeth for children under 19 years c ge.

4. Emergency palliative treatment.

B. The following covered dental expenses all e paid at 90% of the reasonable and customar charge:

1. Dental x-rays, including full mouth x-rays once in any period of five consecutive calendar years, supplementary bitewing x-rays once in any calendar year and such other dental x-rays including, but not limited to, those specified in this paragraph, as are required in connection with the diagnosis of a specific condition requiring treatment.

2. Extractions.

3. Oral surgery.

4. Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally injured teeth.

5. General anesthetics and intravenous sedation when medically necessary and administered in connection with oral or dental surgery.

6. Treatment of periodontal and other diseases of the gums and tissues of the mouth.

7. Endodontic treatment, including root canal therapy.

8. Injection of antibiotic drugs by the attending dentist.

9. Repair or recementing of crowns, nlays, onlays, bridgework, or dentures; relining or rebasing of dentures more than x nths after the installation of an init c

App. C, III. B.9.

replacement denture, but not more than one relining or rebasing in any period of three consecutive calendar years.

10. Inlays, onlays, gold fillings, or crown restorations to restore diseased or accidentally injured teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling restoration.

11. Cosmetic bonding of eight front teeth for children 8 through 19 years of age if required because of severe tetracycline staining, severe fluorosis, hereditary opalescent dentin, or amelogenesis imperfecta, but not more frequently than once in any period of three consecutive calendar years.

C. The following covered dental expenses shall be paid at 50% of the reasonable and customary charge:

1. Initial installation of fixed bridgework (including inlays and crowns as abutments).

2. Initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six-month period following installation).

3. Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:

a. the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed;

App. C, III. C.3.b.

b. the existing denture or bridg· rk cannot be made serviceable and, if : as installed under this dental c er: e, at least five years have elaps· pric: to its replacement; or

c. the existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

Normally, dentures will be replaced by dentures but if a professionally adequate result can be achieved only with bridgework, such bridgework will be a covered dental expense.

4. Orthodontic procedures and treatment (including related oral examinations) consisting of surgical therapy, appliance therapy, and functional/myofunctional therapy (when provided by a dentist in conjunction with appliance therapy) for enrollees under 19 years of age, provided, however, that benefits will be paid after attainment of age 19 for continuous treatment which began prior to such age.

5. Services and procedures for the conservative diagnosis and treatment of temporomandibular joint (TMJ) dysfunction including, but not limited to, related oral examinations, consultations, x-rays, occlusal equilibration, diagnostic models and casts, temporary splints and orthotic appliances. Coverage does not include orthodontic treatment except as provided in App. C, III.C.4. above.

IV. Maximum Benefits For Other Than Accidental Dental Injury

The maximum benefit payable for all cover l dental expenses incurred during a calendar year commencing January 1 and ending the following December 31 (except f · services described in Section III.C.4. and 5. above, and in Section XI below) shall be $1,200 for each enrollee.

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App. C, IV.

For covered dental expenses in connection with orthodontics (including related oral examinations), described in Section III.C.4. above, the maximum benefit payable shall be $1,300 during the lifetime of each enrollee.

For covered dental expenses in connection with TMJ treatment described in Section III.C.5. above, the maximum benefit payable shall be $2,000 during the lifetime of each enrollee.

V. Pre-Determination of Benefits

If a course of treatment can reasonably be expected to involve covered dental expenses of $200 or more, a description of the procedures to be performed and an estimate of the dentist's charges must be filed with the carrier prior to the commencement of the course of treatment.

The carrier will notify the enrollee and the dentist of the benefits certified as payable based upon such course of treatment. In determining the amount of benefits payable, consideration will be given to alternate procedures, services, or courses of treatment that may be performed for the dental condition concerned in order to accomplish the desired result. The amount included as certified dental expenses will be the appropriate amount as provided in Sections III. and IV., determined in accordance with the limitations set forth in Section VI.

If a description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, the carrier reserves the right to make a determination of benefits payable taking into account alternate procedures, services, or courses of treatment,based on accepted standards of dental practice. To the extent verification of covered dental expenses cannot reasonably be made by the carrier, the benefits for the course of treatment may be for a lesser amount than would otherwise have been payable.

This pre-determination requirement will not apply to courses of treatment under $200 or to emergency treatment, routine oral examinations, x-rays, prophylaxes, and fluoride treatments.

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App. C, VI.

VI. Limitations

A. Restorative

1. Gold, Baked Porcelain Restorations, Crowns and Jackets

If a tooth can be restored with a material such as amalgam, payment of the applicable percentage of the charge for that procedure will be made toward the charge for another type of restoration selected by the enrollee and the dentist. The balance of the treatment charge remains the responsibility of the enrollee.

2. Reconstruction

Payment based on the applicable percentage will be made toward the cost of procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension or restore the occlusion are considered optional and their cost remains the responsibility of the enrollee.

B. Prosthodontics

1. Partial Dentures

If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the cost of such procedure will be made toward a more elaborate or precision appliance that the enrollee and dentist may choose to use, and the balance of the cost remains the responsibility of the enrollee.

2. Complete Dentures

If, in the provision of complete denture services, the enrollee and dentist decide on personalized restorations or specialized techniques as opposed to standard procedures,

App. C, VI. B.2.

payment of the applicable percentage of the cost of the standard denture services will be made toward such treatment and the balance of the cost remains the responsibility of the enrollee.

3. Replacement of Existing Dentures

Replacement of an existing denture will be a covered dental expense only if the existing denture is unserviceable and cannot be made serviceable. Payment based on the applicable percentage will be made toward the cost of services which are necessary to render such appliances serviceable. Replacement of prosthodontic appliances will be a covered dental expense only if at least five years have elapsed since the date of the initial installation of that appliance under this dental coverage, except as provided in Section III.C.3. above.

C. Orthodontics

1. If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefits for the services, to the extent remaining, shall be resumed.

2. The benefit payment for orthodontic services shall be only for months that coverage is in force.

VII. Exclusions

Covered dental expenses do not include and no benefits are payable for:

A. charges for services for which benefits are provided under other health care coverages;

B. charges for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist;

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App. C, VII.C.

C. charges for veneers or similar properties of crowns and pontics placed on, or replacing teeth, other than the ten upper and lower anterior teeth;

D. charges for services or supplies that are cosmetic in nature (except as provided in Section III.B. ..), including charges for personalization or characterization dentures;

E. charges for prosthetic devices (including bridges), crowns, inlays, and onlays, and the fitting thereof which were ordered while the enrollee was not covered for dental coverage or which were ordered while the enrollee was covered for dental coverage but are finally installed or delivered to such enrollee more than 60 days after termination of coverage;

F. charges for the replacement of a lost, missing, or stolen prosthetic device;

G. charges for failure to keep a scheduled visit with the dentist;

H. charges for replacement or repair of an orthodontic appliance;

I. charges for services or supplies which are compensable under a Worker's Compensation or Employer's Liability Law;

J. charges for services rendered through a medical department, clinic, or similar facility provided or maintained by the enrollee's employer;

K. charges for services or supplies for which no charge is made that the enrollee is legally obligated to pay or for which no charge would be made in the absence of dental coverage;

L. charges for services or supplies which are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist;

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App. C, VII. M.

M. charges for services or supplies which do not meet accepted standards of dental practice, including, but not limited to, charges for services or supplies which are experimental in nature;

N. charges for services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;

O. charges for services or supplies from any governmental agency which are obtained by the enrollee without cost by compliance with laws or regulations enacted by any Federal, state, municipal, or other governmental body;

P. charges for any duplicate prosthetic device or any other duplicate appliance;

Q. charges for any services to the extent benefits are payable under any health care program supported in whole or in part by funds of the Federal government or any state or political subdivision thereof;

R. charges for the completion of any insurance forms;

S. charges for sealants and for oral hygiene and dietary instruction;

T. charges for a plaque control program;

U. charges for implantology; or

V. charges for services or supplies related to periodontal splinting.

VIII. Proof of Claim

The carrier reserves the right at its discretion to accept, or to require verification of, any alleged fact or assertion pertaining to any claim for dental benefits. As part of the basis for determining benefits payable, the carrier may require x-rays and other appropriate diagnostic and evaluative materials.

App. C, IX.

IX. Alternative Dental Coverage

A. The Corporation may make arrangements for el .ble enrollees to enroll for approved and qualifi alternative dental coverages which may provi for benefits and/or copayments which are differ from those specified in this Appendix. The Corp ation's contributions toward coverage under such a ernative dental coverage shall not be greater than t.e amount the Corporation would have contributed for dental coverage herein.

B. At its option, the Corporation may implement a dental network under which coverage may be limited to covered services obtained from network providers and/or benefits may be reduced or eliminated for covered services obtained from non-network providers. At the Corporation's option, such a network may be substituted for the standard dental coverage under this Appendix, for alternative dental coverage, or both.

X. Definitions

As used in this Appendix, the terms identified below have the meanings stated.

A. "dentist" means a legally licensed dentist practicing within the scope of such dentist's license. As used herein, the term "dentist" also includes a legally licensed physician authorized by license to perform the particular dental services such physician has rendered.

B. "reasonable and customary charge" is defined in Article IV, Section 15 of the Program. However, for purposes of this Appendix "area" means a metropolitan area, a county or such greater area as is necessary to obtain a representative cross-section of dentists rendering such services or furnishing such supplies.

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App. C, X. C.

C. "course of treatment" means a planned program of one or more services or supplies, whether rendered by one or more dentists, for the treatment of a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment commences on the date a dentist first renders a service to correct or treat such diagnosed dental condition.

D. "orthodontic treatment" means preventive and corrective treatment of those dental irregularities which result from the anomalous growth and development of dentition and its related anatomic structures or as a result of accidental injury and which require repositioning (except for preventive treatment) of teeth to establish normal occlusion.

E. "ordered" means, in the case of dentures, that impressions have been taken from which the denture will be prepared; and, in the case of fixed bridgework, restorative crowns, inlays, or onlays, that the teeth which will serve as abutments or support or which are being restored have been fully prepared to receive, and impressions have been taken from which will be prepared the bridgework, crowns, inlays or onlays.

F. "temporomandibular joint (TMJ) dysfunction/disorder" refers to a disorder of the supporting and regulating structures of the jaws including changes in muscles, ligaments and nerves; these changes are generally reversible by time and/or treatment.

G. "accidental dental injury" means an injury to sound natural teeth caused by external forces which occur as the result of a traumatic incident which is sudden and unforeseen and which are not ordinarily associated with chewing or the reasonable use of teeth in normal activity which results in the need for repair and/or replacement of dental structures.

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App. C, XI.

XI. Accidental Dental Injury

For services obtained as the result of an accidental dental injury which occurs while the enrollee is eligible for coverage and enrolled, benefits in excess of the maximums as described in Section IV. are available for repair and/or care of sound natural teeth subject to the following conditions.

A. Benefits are available when:

1. services are covered under this Appendix (except for orthodontic treatment or treatment of temporomandibular joint dysfunction) or would have been covered under this Appendix in the absence of the frequency limitations provided in Sections III. and VI.;

2. the maximum benefits described in Section IV. have been exceeded;

3. the enrollee has sustained a covered accidental dental injury, which is verifiable and documented in the record;

4. services are the direct result of the accidental dental injury; and

5. services are provided within one year subsequent to the date of the accident except:

a. when acceptable evidence is presented to the carrier that unusual or special dental and/or medical needs prevented the provision of services within that time period; or

b. when the dental development of the injured enrollee is incomplete at the time of injury, in which event services must be provided no later than two years after full development is reached.

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App. C, XI. B.

B. Benefits for covered services are subject to:

1. the reasonable and customary charges for repair and/or care of sound natural teeth;

2. a 20% copayment; and

3. a maximum benefit payment per enrollee of $12,000 per qualified occurrence and per lifetime.

C. Coverage under this Section is not available for services for injury caused by normal wear and tear on the teeth or on a prosthetic dental appliance.

App. D.

APPENDIX D

VISION COVERAGE

I. Enrollment Classifications

Vision coverage for a primary enrollee may inc coverage for eligible secondary enrollees as ed in the Program.

II. Description of Benefits

Vision benefits will be payable, subject to the conditions herein, if an enrollee incurs a covered vision expense.

III. Definitions

As used herein:

A. "ophthalmologist" means any licensed doctor of medicine or osteopathy legally qualified to practice medicine, including the diagnosis, treatment, and prescribing of lenses related to conditions of the eye.

B. "optometrist" means any person legally licensed to practice optometry as defined by the laws of the state in which the service is rendered.

C. "optician" means one who makes or sells eyeglasses prescribed by an ophthalmologist or optometrist to cure or correct defects in the eyes, and grinds the lenses or has them ground according to prescription, fits them into a frame, and adjusts the frame to fit the face.

D. "participating provider" means an ophthalmologist, optometrist, or optician who has signed an agreement with the carrier to provide frames to enrollees.

E. "nonparticipating provider" means an ophthalmologist, optometrist, or optician who has not signed an agreement with the carrier to provide frames to enrollees.

App. D, III. F.

F. "contact lenses" means ophthalmic corrective lenses, as prescribed by an ophthalmologist or optometrist, to be fitted directly to the enrollee's eyes.

G. "lenses" means ophthalmic corrective lenses, as prescribed by an ophthalmologist or optometrist, to be fitted into a frame.

H. "frame" means a standard eyeglass frame into which two lenses are fitted.

I. "covered vision expense" means the reasonable and customary charges for vision care services and materials, as described in Section IV., when provided by ophthalmologists, optometrists, and opticians for each enrollee.

IV. Benefits

Benefits will be paid for the covered vision expenses described in A. and B. below, less any copayment as described in C. below.

A. Vision Examinations:

1. Refraction, including case history, coordinating measurements, and tests;

2. The prescription of glasses where indicated; and

3. Examination by an ophthalmologist, upon referral by an optometrist, within 60 days of a vision examination by the optometrist.

B. Lenses and Frames:

When lenses are prescribed by an ophthalmologist or optometrist, the necessary materials and professional services connected with the ordering, preparation, fitting, and adjusting of:

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App. D, IV. B.1.

1. Lenses (single vision, bifocals, trifocals, lenticular). If the enrollee selects lenses, the size of which results in additional charge, only the reasonable and customary charge for normal size lenses of the same material and prescription will be considered a covered vision expense. If the enrollee selects photochromic lenses or lenses with a tint other than Number 1 or Number 2, only the reasonable and customary charge for clear lenses of the same material and prescription will be considered a covered vision expense.

2. Contact lenses following cataract surgery, or when visual acuity cannot be corrected to 20/70 in the better eye except by their use, or when medically necessary due to keratoconus, irregular astigmatism or irregular corneal curvature. If contact lenses are prescribed for any other reason, $65 is the maximum amount that will be considered a covered vision expense.

3. Frames. If frames are obtained from a participating provider, the enrollee may make a selection from the display shown by the participating provider and there will be no out-of-pocket expense to the enrollee other than as described under "copayments". However, if the selection at the participating provider is not from the display shown, or if the enrollee obtains frames from a nonparticipating provider, $15 is the maximum amount that will be considered a covered vision expense.

C. Copayments:

For each enrollee, there is a $7.00 copayment applicable to the covered vision expense for each vision examination and a $10.00 copayment for the combined covered vision expenses for lenses, contact lenses, and frames. The total copayment for each enrollee, during a calendar year, will not exceed $17.00.

SALARIED HEALTH CARE PROGRAM

App. D, V.

V. Frequency Limitations

For each enrollee, there are the following limitations on the frequency with which charges for certain services and materials will be considered covered vision expenses:

Vision Examination	-	Once during a calendar year, except as provided in Section IV.A.3.
Lenses	-	Once during a calendar year.
Frames	-	Once during two consecutive calendar years.

The limitations on lenses, contact lenses, and frames apply whether or not they are a replacement of lost, stolen, or broken lenses, contact lenses, or frames.

VI. Exclusions

A. Any lenses which do not require a prescription;

B. Medical or surgical treatment of the eye;

C. Drugs or any other medication;

D. Procedures determined by the carrier to be special or unusual, such as, but not limited to, orthoptics, vision training, subnormal vision aids, aniseikonic lenses, and tonography;

E. Vision examinations or materials furnished for any condition, disease, ailment, or injury arising out of or in the course of employment; and

F. Vision examinations performed and lenses and frames ordered:

1. before the enrollee became covered for this coverage;

2. after the termination of the enrollee's coverage; or

3. to the extent that they are obtained without cost to the enrollee.

SALARIED HEALTH CARE PROGRAM

App. D, VII.

VII. Alternative Vision Coverage

A. The Corporation may make arrangements for enr .lees to obtain vision services through a preferred /ision provider program or other alternative vision coverage which may provide for benefits and/ r copayments which are different from those sp .cified in this Appendix. The Corporation's contributions toward coverage under such alternative vision coverage shall not be greater than the amount the Corporation would have contributed for vision coverage herein.

B. At its option, the Corporation may implement a vision network under which coverage may be limited to covered services obtained from network providers, and/or benefits may be reduced or eliminated for covered services obtained from non-network providers. At the Corporation's discretion, such a network arrangement may be substituted for the standard vision coverage under this Appendix, for the alternative vision coverage, or both.

App. E

APPENDIX E

EXTENDED CARE COVERAGE

I. Definitions

To the extent they are not in conflict with the following, the definitions contained in Article IV and in Appendix A of the Program are incorporated herein by reference. For the purposes of this Appendix:

A. "nurse professional" means a registered nurse (RN); or a licensed practical nurse (LPN), nurse practitioner, nurse clinician, home health aide or nurse's aide who is appropriately licensed, where required, and qualified to provide nursing services under the supervision of a physician or a registered nurse;

B. "nursing home" means a basic or intermediate care facility licensed and operated in accordance with the laws pertaining to nursing homes, which provides 24-hour nursing care under medical supervision to ill or disabled enrollees who are unable to care for themselves; and

C. "unskilled care" means care which, although prescribed by a physician, is typically provided to assist the patient with the activities of daily living including, but not limited to, bathing, dressing, incontinent care, skin care, and meal preparation. Although such care requires only basic skills and training, it may be provided in a licensed nursing home, by a home health care agency, or by a privately contracted, qualified nurse professional.

The Extended Care Coverage (ECC) carrier shall have discretionary authority to interpret, construe and apply the above provisions of the Program. The carrier's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

SALARIED HEALTH CARE PROGRAM

App. E, II.

II. Eligibility, Enrollment and Contributions

A. Extended Care Coverage (ECC) is available to primary enrollees eligible for and enrolled in Medical Plan coverage under the Program, with the exception of:

1. Employees in Hawaii;

2. Employees classified as Flexible Service Employees, International Service Personnel or Cooperative Students;

3. Laid-off salaried employees covered under the provisions of the General Motors Income Protection Plan for Salaried Employees;

4. Primary enrollees who reside in Canada and elect the Optional Canadian Health Care Coverage (OCHCC); and

5. Retirees and surviving spouses who have waived, discontinued or otherwise terminated ECC in their own right on or after January 1, 1994, and who have not been (a) continuously enrolled either in ECC under another primary enrollee or in the Comprehensive Medical Expense Insurance Program coverage applicable to OCHCC enrollees, or (b) included in the coverage elections of an employee eligible for coverage under the Program.

B. With the exception of sponsored dependents, secondary enrollees are eligible for ECC if they are eligible and enrolled for Medical Plan coverage under a primary enrollee enrolled in ECC.

C. An ECC-eligible employee who elects and is enrolled for Medical Plan coverage under the program will be enrolled automatically in ECC, regardless of the enrollment option elected (BMP, EMP, PPO or HMO). If the employee's Medical Plan coverage is terminated, or if the employee's status changes to one which would not entitle the employee to ECC, the ECC is terminated; if the employee's Medical Plan coverage

App. E, II. C.

is reinstated, or if the employee returns to a status which entitles the employee to ECC, it will be reinstated. Employee contributions for ECC will be included in the calculation of contributions for the Medical Plan options.

D. Retirees and surviving spouses eligible for Medical Plan coverage under the Program will make a separate contribution for ECC, if it is elected. The contribution schedule is subject to periodic adjustment, at the discretion of the Corporation.

1. The enrollment status [self only, self and spouse, self and child(ren) or self and family] for ECC will be the same as that for the Medical Plan enrollment status chosen by the retiree/surviving spouse.

2. If the retiree/surviving spouse was enrolled in the Comprehensive Medical Expense Program (CMEP) under a prior Program as of December 31, 1992, ECC was initiated and will be continued unless and until a notice of waiver or termination is received by the Corporation, or the retiree/surviving spouse fails to pay any contributions required to maintain coverage.

3. If the retiree/surviving spouse was not enrolled in CMEP under a prior Program as of December 31, 1992, ECC is activated only after receipt by the Corporation of an application for enrollment. If the application was received in January 1993, ECC became effective February 1, 1993. If the application was received on or after February 1, 1993, but prior to December 31, 1993, coverage became effective the earlier of January 1, 1994 or the first day of the sixth month following receipt of the application.

4. A retiree or surviving spouse who does not elect to enroll in, or to maintain enrollment in ECC on or after January 1, 1994, will not be permitted to reenroll in ECC at a later date unless, during the intervening period, the retiree or surviving spouse has been enrolled in ECC under another primary enrollee, included as a secondary enrollee in the Medical Plan

App. E, II. D.4.

elections of a salaried employee or enrolled under the OCHCC. The same prohibition will apply to an individual who becomes a salaried retiree or a surviving spouse of a salaried employee or retiree on or after January 1, 1994, and elects not to enroll in ECC at the time of retirement or enrollment as a surviving spouse, or who initially elects but then discontinues ECC.

III. Covered Expenses and Benefits

A. ECC coverage applies only to long term and/or custodial care needs. Accordingly, the situations in which ECC benefits may be payable, subject to the specified maximums, are if an enrollee exhausts hospital or skilled nursing facility or home health care coverage under the Medical Plan of the Program; if home health care services for an enrollee exceed the requirements for coverage under that Plan; or if an enrollee incurs expenses for private duty nursing services or custodial care not covered under that Plan.

B. There are no deductibles and copayments applicable to services covered under this Appendix.

C. Determinations made by Medical Plan carriers with regard to the nature of care being provided to an enrollee will not control benefit determinations for ECC, nor will determinations of the ECC carrier control benefit determinations under other appendices of the Program. To the extent that the ECC benefits payable are a function of the nature of the service being performed (i.e., skilled, unskilled or a combination of the two), the medical necessity of the services, the reasonable and customary charge for such services or the approved status of the provider for ECC purposes, the ECC carrier shall have discretionary authority to interpret apply and construe the provisions of the Program. The ECC carrier's exercise of this authority shall be given full force and effect unless it is determined by the Plan Administrator to have been inconsistent with the Program provisions or arbitrary and capricious.

SALARIED HEALTH CARE PROGRAM

App. E, III. D.

D. The maximum benefit payable under this Appendix for services incurred during any one calendar year (January 1 through December 31) is $50,000 for each enrollee, subject to the provisions below. Claims must be received by the carrier no later than the last day of the calendar year following the calendar year in which the expenses are incurred.

1. Coverage will be provided at the reasonable and customary daily rate for skilled or mixed skilled and unskilled care for:

   a. Medically necessary non-custodial hospital or skilled nursing facility admissions which exhaust the Medical Plan limits;

   b. Skilled hospital or skilled nursing facility admissions which are not covered under the Medical Plan due to the Medical Plan carrier's determinations that the admissions are custodial in nature;

   c. Admissions to nursing homes approved by the ECC carrier, for services considered by the ECC carrier to be skilled in nature; and

   d. Skilled care being provided in the home by a qualified home health care agency or by a qualified nurse professional but which does not meet the criteria for coverage under the Medical Plan provisions, exceeds the intermittent or part-time criteria or exhausts the Medical Plan limits of the option elected.

   However, if Medical Plan benefits are denied or reduced solely due to failure to use providers approved by the Medical Plan option carrier, no benefits are payable.

2. Coverage will be provided at a maximum of $35 per day for unskilled care delivered in a hospital, skilled nursing facility, nursing home or in the patient's home by nurse professionals.

App. E, III. D.3.

3. Coverage will be provided for medical supplies not covered under another provision of the Program (e.g., prescription drugs, durable medical equipment) for an enrollee admitted to a hospital or skilled nursing facility for unskilled custodial care, or for an enrollee confined to the home and receiving benefits under this Appendix but not receiving home health care services under the Medical Plan. For enrollees receiving home health care services under the Medical Plan, medical supplies are covered under App. A, III.D.2.c.(3). Supplies covered under this Appendix are in addition to the $35 daily allowance for actual care of the enrollee.

IV. Limitations and Exclusions

Covered expenses will not include, and benefits are not payable for:

A. deductibles and copayments applied to covered expenses under any option available under another Appendix of this Program or out-of-pocket expenses incurred as sanctions because of failure to satisfy the Program provisions under such appendices;

B. services in the home in connection with routine nursing care of newborn children;

C. services not prescribed by a physician;

D. education or training (including such services when directed toward learning, behavioral or developmental deficiencies);

E. amounts covered by public programs providing benefits (such as those under laws pertaining to Worker's Compensation, non-occupational disability, old age assistance, veteran's assistance, and any Federal or state health insurance act providing nursing benefits);

F. amounts reimbursed by Medicare;

G. amounts in excess of the reasonable and customary charge or which are not considered to be necessary as determined by the carrier;

SALARIED HEALTH CARE PROGRAM

App. E, IV. H.

H. charges which the enrollee is not required to pay or charges which would not have been made if no benefit coverage had existed;

I. charges which duplicate benefits paid under another Appendix of the Program;

J. services provided to the enrollee by a person related to the enrollee by blood or marriage;

K. services provided by a halfway house, group home, adult foster care facility and the like;

L. non-medical supplies including, but not limited to, personal hygiene products, over-the-counter medications and personal items (including disposable briefs and diapers);

M. private duty nursing services for enrollees admitted to hospitals, skilled nursing facilities or nursing homes; and

N. charges for services rendered prior to the effective date of, or after termination of coverage under this Appendix. However, if a patient's covered and continuous admission to a hospital, skilled nursing facility or nursing home commences prior to termination of the coverage, benefits may be paid for that patient's admission until the earliest of discharge from the facility, exhaustion of the calendar year maximum and the end of the calendar year in which coverage is terminated.

App. F

APPENDIX F

INTERNATIONAL HEALTH CARE PLAN

The provisions of the General Motors Salaried Health Care Program (the Program) shall apply to individuals classified as International Service Personnel (ISP) except for the modifications detailed in this Appendix. Throughout the remainder of this Appendix, the International Health Care Plan will be referred to as the Plan.

I. Establishment, Financing and Administration of the Plan

The provisions of Article I of the Program in effect on December 31, 1992 apply to this Plan.

II. Health Care Coverages

The provisions of Article II of the Program do not apply to this Plan. The Plan provides for core coverages consisting of hospital, surgical, medical, prescription drug, and hearing aid coverages as set forth in Section VI.A. of this Appendix and substance abuse and mental health coverages as provided under the International Health Care Plan of the Program in effect on December 31, 1992. The Plan also provides for non-core coverages consisting of dental coverage as set forth in Section VI.B. of this Appendix, vision coverage as set forth in Section VI.C. of this Appendix, and optional Comprehensive Medical Expense Program (CMEP) coverage, as provided under the Program which was in effect on December 31, 1992.

III. Enrollment, Eligibility, Commencement, Contributions and Continuation

In addition to the modifications detailed below, the provisions of Article III of the Program apply only to those coverages established in Section VI. below.

A. Enrollment

Subsections (a)(2), (3) and (8) of Article III, Section 1 of the Program do not apply to this Plan.

SALARIED HEALTH CARE PROGRAM

App. F, III. B.

B. Dates of Eligibility and Commencement of Coverages

Subsection (a) of Section 2 of Article III of the Program does not apply to this Plan and is replaced by the following:

1. ELIGIBILITY

Eligibility for the Plan generally is limited to:

a. United States employees of General Motors Corporation and its non-consolidated subsidiaries who are classified as International Service Personnel (ISP-U.S.), except those assigned to locations in Canada but who continue to reside in the United States and who continue to be covered under the Program applicable to United States employees;

b. foreign employees of General Motors Corporation and its non-consolidated subsidiaries who are working in the United States and are classified as International Service Personnel (ISP-O.S.);

c. individuals who are residing in the United States under the auspices of General Motors Corporation and are classified by General Motors Corporation as:

(1) fellowship participants;

(2) long-term training program personnel; or

(3) short-term training program personnel (short-term training program personnel are not eligible for dental, vision or CMEP coverage); and

d. eligible dependents (as defined under the Program) of those enrollees identified in subsections a. through c. above.

SALARIED HEALTH CARE PROGRAM

App. F, III. B.2.

2. EFFECTIVE DATES

a. Core, Dental, and Vision Coverages

Eligible individuals enrolled for th Plan will be covered for core, dental, and vis. coverages during the specific periods as follows:

(1) ISP-U.S.:

Coverage under the Plan generally becomes effective with the first day of the month following the change of status unless (a) the change of status is on the first day of the month, in which case the coverage is effective that day, or (b) the individual is hired directly to the ISP-U.S. assignment, in which case coverage is effective upon the date of hire;

(2) ISP-O.S.:

Coverage under the Plan generally becomes effective with the first day of the month following the change of status unless the change of status is on the first day of the month in which case the coverage is effective that day;

(3) Fellowship Participants, and Long- and Short-Term Training Program Personnel:

Coverage under the Plan shall become effective on the first date an individual is within the United States and classified by General Motors as a fellowship participant, long-term training program personnel, or short-term training program personnel. Coverage will remain in effect until the earlier of (a) the date the individual leaves the United States or (b) the date the individual is no longer classified by General Motors as a fellowship participant, long-term training program personnel, or short-term training program personnel.

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App. F, III. B.2.b.

b. Comprehensive Medical Expense Program (CMEP)

Eligible individuals who choose to enroll for the optional CMEP and make the required monthly contribution will be covered only during the specific periods indicated below:

(1) If enrollment occurs within 31 days after core coverages become effective, CMEP coverage will become effective on the first day of the month next following the date of enrollment;

(2) If enrollment occurs more than 31 days after core coverages become effective, or if reenrollment occurs after CMEP coverage is voluntarily canceled, CMEP coverage will become effective on the first day of the sixth month next following the date of receipt of an application for enrollment or reenrollment.

IV. Definitions

To the exent they are not in conflict with the provisions of this Appendix F, the provisions of Article IV of the Program apply to this Plan.

V. Special Benefit

Article V of the Program does not apply to this Plan.

VI. Coverages

A. Core Coverages

The Traditional option of the Informed Choice Plan, under the Program which was in effect on December 31, 1992, applies to this Plan except as modified below.

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App. F, VI. A.1.

1. Other than the copayments required for prescription drugs, the deductible, copayment and predetermination requirements of that Program do not apply to this Plan.

2. Hospital coverage for outpatient laboratory and pathology examinations is provided on the same basis as if performed inpatient.

3. Diagnostic laboratory and pathology coverage is provided for routine mammography screenings which are performed in accordance with the guidelines established for Appendix A.

4. The Mail Order Prescription Drug program is not available under this Plan.

5. The list of maintenance legend drugs which may be dispensed in 100-unit doses shall also include

Amlodipine
Atenolol/Chlorthalidone
Benazepril
Benztropine
Betaxolol
Bisoprolol
Captopril/HCTZ
Carbidopa/Levodopa
Chlorthalidone/Clonidine
Diclofenac Sodium
Doxazosin
Enalapril/HCTZ
Etodolac
Felodipine
Flurbiprofen
Fosinopril
Guanfacine HCL
HCTZ/Reserpine/Hydralazine
Ibuprofen
Indapamide
Isradipine
Lisinopril/HCTZ
Lovastatin
Medroxyprogesterone

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App. F, VI. A.5.

Nabumetone
Nicardipine
Pravastatin
Propranolol/HCTZ
Quinapril
Ramipril
Selegiline
Simvastatin
Terazosin
Trihexyphenidyl

6. Hearing aid benefits are provided only for services obtained in the United States from participating providers.

7. Program standards for durable medical equipment (DME) and prosthetic and orthotic appliances (P&O) have been amended to include equipment and external appliances approved for reimbursement under Medicare Part B as of October 1, 1993. In addition:

   a. DME coverage is provided for continuous passive motion devices for use following surgery to the elbow or shoulder (Medicare covers it only following total knee replacement); and

   b. P&O coverage is provided for

      (1) therapeutic shoes prescribed for diabetic enrollees not eligible for Medicare, limited to diagnosis criteria established by the Control Plan;

      (2) any style of orthopedic shoe, in addition to a basic oxford, when the shoe is an integral part of a covered brace; and

      (3) all orthopedic shoe inserts, arch supports and shoe modifications used with a shoe that is attached to a covered brace.

8. Case management is not available under this Plan.

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App. F, VI. A.9.

9. The mental health and substance abuse coverages provided in the International Health Care Plan of the Program which was in effect as of December 31, 1992 apply to this Plan.

B. Dental Coverage

The dental coverage available under the Program which was in effect as of December 31, 1992 applies to this Plan except that pre-determination does not apply to International Service Personnel (ISP) or their covered dependents receiving dental services outside the United States.

C. Vision Coverage

The vision coverage of the Program which was in effect as of December 31, 1992, applies to this Plan. However, the maximum covered vision expense for "cosmetic" contact lenses is increased to $65 effective January 1, 1994.

D. Comprehensive Medical Expense Program

The CMEP coverage of the Program which was in effect as of December 31, 1992 is available to enrollees of this Plan.

E. Extended Care Coverage

The Extended Care Coverage of the Program does not apply to enrollees of this Plan.

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